Frequently Asked Questions

GENERAL QUESTIONS	
Questions	**Answers**
1. When is the submission deadline for the 2005 CARE Act Data Report (CADR)?	The submission deadline for all CARE Act Titles is midnight on March 15, 2006. If submitting paper CADRs by mail, they must be received by February 15, 2006 at Data Support (postmarked no later than February 10, 2006) or faxed to Data Support by February 15. Grantees must still approve all CADRs through the EHB by March 15, 2006.
2. If submitting by paper, where do I send my completed CADR?	Providers: All paper CADR submissions must be sent to your grantee of record for approval. Grantees: All paper CADR submissions should be faxed or mailed to Data Support by February 15: WRMA/CSR Ryan White Project Attn: Ryan White CARE Act Data 2107 Wilson Blvd., Suite 1000 Arlington, VA 22201 Fax: 703-312-5230
3. What is the difference between a grantee and a provider?	A grantee receives CARE Act funds directly from HRSA. A provider receives CARE Act funds from an agency other than HRSA.
4. Do program and agency mean the same thing or are they different?	For the purpose of the CADR, they mean the same thing.
5. How do agencies access the CADR Web system?	Grantees must access the CADR Web system through the EHBs. Providers may access the system at https://performance.hrsa.gov/hab. Providers who used the Web system last year may log in with their existing usernames and passwords, or create new user accounts using the registration code furnished by their grantee(s) of record. Instructions for accessing the Web system are included in the annual CADR mailing.
6. Is there a minimum browser requirement to access the CADR Web system?	Yes. You must have Internet Explorer version 5.5 or higher. Netscape is not supported.
7. Where can I download the CADR form and instructions?	The CADR form and instructions may be downloaded in PDF format at http://www.hab.hrsa.gov/tools. You must have Adobe Acrobat Reader software, which can be downloaded by clicking on the Adobe PDF icon in the center left side of the screen.
8. Is it acceptable to submit some provider CADRs on the Web and some on paper?	Yes. However, it is preferred that all agencies use the Web system.
9. How does a multiply funded agency report Title IV Adolescent Initiative (AI) data?	Title IV Adolescent Initiative (AI) programs should submit a SEPARATE CADR containing all of their AI data only, even if funded under other CARE Act Titles. They should submit a second CADR containing the data from the other Titles under which they are funded. This is the only instance in which two forms may be completed.

10. A provider may receive funding from grantees through different CARE Act Title programs. For example, one provider in Northern VA may see clients funded under the VA Title II program and the DC Title I EMA. This same provider must report its data to the state of VA and to the DC EMA. Would this provider complete two CADRs for VA and DC, reporting Title II and Title I data separately?	No. Each provider completes one CADR for all clients served during the reporting period and sends an identical copy to each grantee of record, even if some information is not relevant to a particular grantee. If a grantee requires Title-specific information from its provider, it should be requested independent of the CADR.
11. What is an EIN?	EIN stands for Employer Identification Number. This is often the same as your agency's Taxpayer ID number.
12. If two different programs share the same Taxpayer ID number, do they have to complete a single CADR?	No. Each program completes its own CADR and submits it to the grantee. For example, in Florida, all the local health departments have the same Taxpayer ID number, but each health department would complete its own CADR and submit it to the Florida Department of Public Health (the Title II grantee).
13. Why is there no longer a section within the CADR to record ADAP information?	ADAP/APA information is now collected in a separate quarterly report. However, you must still indicate on the CADR (Item 17) whether your agency administered an ADAP/APA program.
14. Does a provider who only provides indirect services need to fill out a CADR?	An agency that provides indirect services should complete Items 1-16 and stop.
15. Will there be a penalty for a large number of unknowns reported for specific items on the CADR?	Grantees are expected to work with their service providers to establish procedures for collecting all information on the CADR for all clients served during the reporting period. Project officers within the individual Title programs will be notified when grantees report large numbers of unknowns or omit data. HAB will decide how to handle such deficiencies.
16. To count an affected individual as a client, does the infected family member or partner need to be a client of the agency?	Yes. To report this individual as a client, he/she must be linked to a client who is HIV-positive and received at least one eligible service during the reporting period.
17. Will grantees be provided with electronic copies of their data reports?	Yes. Following the data verification process, each grantee will receive an email containing all of their original CARE Act data (as submitted prior to verification).
18. How can I obtain the Ryan White Care Act Annual Data Summary?	Summary reports are normally posted on the HRSA Web site shortly after they're produced. You can also request one through your HAB project officer.
19. Can I update my CADR after it has been submitted?	Yes, but only prior to the submission deadline. If your CADR was submitted via the Web, use the "Unsubmit" feature to request that your CADR be returned to "Working" status. If you submitted a paper CADR, fax updates to Data Support with an explanation.

COVER PAGE	
Questions	**Answers**
1. If submitting CADRs via the Web system, do I need to send a signed cover page to Data Support?	No. Because grantees must now approve CADRs through the EHB, the cover page is no longer required. However, if you intend to submit paper CADRs, you may include a completed cover page with your submission package to verify its contents.

SECTION 1: SERVICE PROVIDER INFORMATION	
Questions	**Answers**
1. Item 3: Whose contact information should be provided?	Provide the contact information for the person responsible for the data in the report.
2. Item 5: I only capture client information every six months, and the six-month period does not fall at the end of the reporting period. Am I required to ask for the information again?	No. Report the most recent information available for each client.
3. Item 6: How do I determine whether to use reporting scope "01" or "02"?	HAB's preference is that all grantees report on all clients who received services eligible for CARE Act funding (reporting scope "01") during the reporting period; however, grantees may contact their project officer at HAB for written permission to use the funded reporting scope "02." **Grantees who want to do this must be able to track clients and services by funding stream**. Note: Grantees need to make sure all of their providers use the same reporting scope, and should inform them of the scope to use before they begin collecting their data.
4. Item 6: With regard to reporting scope "01," which services are eligible for CARE Act funding?	Services eligible for CARE Act funding include counseling and testing and all services listed in Section 3 (Item 33). Under reporting scope "01," grantees and service providers are responsible for reporting on all clients receiving services eligible for CARE Act funding.
5. Items 11-14: Should the amount awarded or received be reported?	Report only the amount actually received during the reporting period.
6. Items 11-14: Should providers subtract unexpended funds from the funding reported?	No. Providers should report all funding received during the reporting period whether or not it was expended.
7. Items 11-14: Should grantees include the funds they distributed to their providers in the total amount of funding they received?	Yes. All funding received should be included regardless of whether the funds were used strictly by your agency or distributed to providers.
8. Items 11-14: Is it permissible to report fiscal year data?	No. Grantees must annualize their fiscal data as illustrated on page 9 of the instructions.
9. Item 13: Should Title III Capacity Building grant funding be reported?	No. Only Title III EIS grant funding should be reported.
10. Item 15: Should DRP funding be reported?	No. Title I, II, III, and IV CARE Act funds that were expended on oral health care should be reported, regardless of funding scope. The DRP does not use the CADR for annual reporting.
11. Item 16: Should a grantee complete this item if they did not contract out for support services?	Yes. They should indicate any administrative services that were provided in-house.
12. Item 16: A Title I EMA contracts with an agency that provides only technical assistance and quality management. How should this provider report?	This provider should complete Items 1-16 only, checking "yes" to the two support services in Item 16. This provider should then submit their CADR to the Title I EMA.
13. Item 19: If a grantee is encouraged to target incarcerated individuals by the state but does not receive money specifically for this, does it still report in Item 19 that it targets incarcerated individuals?	Yes. Grantees should report all populations targeted even if they do not receive or allocate money specifically for this purpose.

SECTION 2: CLIENT INFORMATION	
Questions	**Answers**
1. Item 23: How does a provider report a client who is initially diagnosed as HIV-positive, but is later shown—through subsequent testing results—to be HIV-negative?	The provider should report whatever the diagnosis is at the end of the reporting period.
2. Item 23: How are HIV-exposed infants categorized on the CADR?	If their status is known (HIV-positive or negative), then it should be reported on the appropriate line. If their HIV status is unknown, then it should be reported as HIV-indeterminate.
3. Item 23: Where does a provider report individuals whose HIV status is unknown?	The individuals should be reported as HIV status unknown/unreported. If they are under 2 years of age they should be reported as HIV-indeterminate.
4. Items 23-31: What is the correct way to report clients who died during the reporting period?	Deceased clients should be reported under the category in which they were last reported before their death.
5. Item 24: If a client is discharged and then later re-enters the program, should the individual be counted as a new client?	The client who returns for care after an extended absence should not be considered new unless past records of their care are not available.
6. Item 25: Is there a standard breakdown for gender?	The classifications used represent HAB's standard for reporting gender.
7. Item 27: How should providers report clients who do not self-report a race/ethnicity?	All agencies should make every effort to collect demographic information from all clients. If a client does not self-identify a race/ethnicity, then the client should be reported in the unknown/unreported category.
8. Item 28: Who is included in a household?	A household can include family members, a spouse, partner, or non-family members who reside together. The income of all individuals (over the age of 15) that occupy a single residence should be included in the household income reported in Item 28, unless an individual does not directly contribute toward the daily living expenses of the other people within the residence (e.g. someone who rents a room in a house and pays his/her own bills and living expenses separate from the other people that occupy that house).
9. Item 28: Household income - clients who are HIV-positive and affected are listed in two separate columns, but some households include both HIV-positive and affected clients. How should this be reported?	The total household income for each client receiving services would be the income of all HIV-positive and affected clients living in the household. Each client would be reported separately but if s/he resides in the same household, the same income information would be entered for each client.
10. Item 28: How should providers categorize the household income of clients who are homeless?	Homeless clients should be reported in the appropriate income category. If the clients report no income, count them in the "Equal to or below the Federal poverty line" category.
11. Item 29: How should providers categorize the housing/living arrangements of clients who are homeless?	Include homeless clients in the "Non-permanently housed" category.

12. Item 30: How do providers report a client with more than one type of medical insurance?	The primary insurance, or the one that reimburses the most, should be reported. The list of insurance types in Item 30 is not hierarchical.
13. Item 30: How do providers report clients whose only source of medical insurance is Title III funds?	These clients should be reported in the "No insurance" category.
14. Item 30: If a grantee pays private insurance premiums for clients, under which insurance category should these clients be reported?	Classify these clients as publicly insured. If you administer a Health Insurance Program (HIP), include these clients in Section 7.
15. Item 32: What is the definition of inactive?	Each individual grantee/provider determines the period of time that must pass before a client is considered inactive.

SECTION 3: SERVICE INFORMATION	
Questions	**Answers**
1. Item 33: Some Title IV funded agencies provide services to exposed infants whose HIV status is not yet known. How should these individuals be reported in Section 3?	These infants would be categorized as HIV-indeterminate. HIV-indeterminate clients should be reported in the HIV+ columns.
2. Item 33: Can CARE Act funds be used to provide services to prisoners?	Providers should only use CARE Act funds to provide discharge-planning services to prisoners (case management, etc.). Please see ***HAB Policy Notice 01-01: Use of Ryan White CARE Act Funds for Transitional Social Support and Primary Care Services for Incarcerated Persons.*** Visit the HAB Web site at http://hab.hrsa.gov/tools/adap/ for more information.
3. Item 33: Should grantees and service providers report fee-for-service treatments or services on the CADR?	Yes. Providers should track all services that they pay for.
4. Item 33: What constitutes a visit?	"Visit" should be defined by your program. However, a client may only have one visit for each service category per day. For a residential substance abuse treatment center, each day in a residential facility equals one visit. For example, if a client spends 20 days in a residential facility, this counts as 20 visits.
5. Item 33: Can a client be reported under more than one service category in one day?	Yes. For example, a client can receive mental health services, case management and transportation services all in one visit.
6. Item 33b/33aa: A provider has two psychologists who provide services to clients. One psychologist is within the HIV CARE program and receives CARE Act funds and the other is not in the HIV care program and does not receive any CARE Act funds. How should clients who receive services from these psychologists be reported in the service information table?	Clients who receive services from the psychologist funded by CARE Act monies should be reported in 33b, Mental health services. If the provider reports under scope "01" in Item 6, clients who receive services from the psychologist not funded by CARE Act monies also should be reported in 33aa. However, if the provider reports under scope "02," services provided by the psychologist who does not receive CARE Act funds would not be reported.
7. Item 33j and 33n: If client advocacy is provided during a case management visit, under which category should this be reported?	If client advocacy services were provided at the time of a case management visit, report under both service categories.

8. Item 33l: Under which service category should providers report child respite care?	Child respite care falls under ”Child care services.” However, this category does not include child care for working parents; it only includes child care when parents need someone to watch their children while they receive services.
9. Item 33r: Under which service category should a provider report groceries, food vouchers, and food stamps?	Report these services in Item 33 under ”Emergency Financial Assistance.”
10. Item 33u: Are rental subsidies included in the definition for housing services in 33u?	No. CARE Act funds should not be used to provide clients with assistance in paying their rent. This type of service falls under HUD.
11. Item 33x: Should providers be discouraged from reporting anonymous clients for outreach services?	Yes. This category should **NOT** be used for reporting any anonymous clients. If grantees or service providers conduct outreach activities in large settings such as health fairs, individuals should not be included on the CADR unless they received at least one eligible CARE Act service during the reporting period and are accounted for in Section 2.
12. Item 33z: How should a provider document mental health services for an affected client?	Title IV funded agencies should report these individuals under 33b, “Mental health services.” All other Titles should report these individuals under 33z, “Psychosocial support services.”
13. Item 33aa: Where does a Title III provider document a client referred for substance abuse treatment and counseling services?	Any agency referring clients for substance abuse services should report these services in 33aa. The agency that actually provides the services should report the client and number of visits in 33d.
14. Item 33aa: Do referral fees need to be paid in order for an agency to count a referral?	No.
15. Item 33aa: How is “Referral for health care/supportive services” defined by HAB?	It is defined as the act of directing a client to a service in person or through telephone, written, or other type of communication. Referrals may be made formally from one clinical provider to another, within the case management system by professional case managers, informally through support staff, or as part of an outreach program.
16. Item 33aa: If clients are sent to another location for lab work, do they still need to be reported under this service category?	No. A medical service visit includes lab work. If a client goes to a doctor for a medical visit and is sent somewhere else for labs, it is counted as one visit, NOT as two medical visits nor as a medical visit and a referral.
17. Item 33ae: If a clinician talks about treatment adherence as part of a client's medical visit, should that visit be counted as a medical visit as well as a treatment adherence visit?	No. Only counseling or special programs devoted exclusively to treatment adherence should be counted as a visit for treatment adherence. A medical visit that includes a discussion of treatment adherence should not be counted as both a medical visit and a treatment adherence visit.

SECTION 4: HIV COUNSELING AND TESTING (C&T)	
Questions	**Answers**
1. Which service providers should complete this section?	Providers funded under any and all Titles that provide HIV antibody counseling and testing (C&T) should complete this section. C&T is a required component of Title III programs.

2. Should grantees report all clients who received HIV counseling and testing (C&T) during the reporting period or only those clients who received C&T funded by CARE Act funds?	Grantees/providers that report under scope "01" and provided C&T during the reporting period, must complete all items in Section 4 for all individuals who received C&T, regardless of who paid for the testing. Grantees/providers that report under scope "02", and used CARE Act funds to pay for the service must complete Section 4 for those clients who received C&T as a CARE Act-funded service. Those who report using scope "02" and provided C&T, but did not use CARE Act funds for these services, should answer "yes" to Item 34, "no" to Item 35, and skip to Section 5.
3. Can Title I and II agencies use CARE Act funds for HIV counseling and testing?	Yes. C&T is now funded as a component of Early Intervention Services for Title I and II grantees. For C&T to be considered part of EIS, agencies must also provide at least one other early intervention service.
4. Under HIV counseling and testing, if someone tests negative, should s/he be reported on the CADR?	These individuals are accounted for in Items 36, 37, and 39 on the CADR. However there is no place to specify the number of individuals who test negative.
5. Item 34b: Where should infants who are tested for HIV, but whose mothers are not clients, be reported?	Infants who are tested for HIV should be reported in Section 4, Item 34b, but should be excluded from the remaining items in the section.
6. Items 36-39: How can anonymous clients be entered into CAREWare?	Anonymous clients cannot be entered into CAREWare; however, after uploading your CADR from CAREWare to the Web system, you can manually add anonymous clients to the appropriate categories.
7. Item 41: When should an agency answer "yes" to Partner Notification Services?	An agency should answer "yes" to this item if there are policies and procedures in place to provide Partner Notification Services in a standardized way to all clients testing positive for HIV disease.

SECTION 5: MEDICAL INFORMATION	
Questions	**Answers**
1. How should infants be reported in Section 5?	Infants should be included in this section if they are HIV-positive/indeterminate and had at least one ambulatory/outpatient medical care visit during the reporting period.
2. What is the definition of Medical Service Provider?	A Medical Service Provider is any service provider who provided ambulatory/outpatient medical care (Item 33a). Other individuals who have authorized access to medical information, but do not actually provide ambulatory/outpatient medical care, should not complete section 5.
3. As an agency reporting for multiple fee-for-service medical providers, am I responsible for filling out Section 5: Medical Information?	Yes. If you provide reimbursement to doctors providing clients with medical visits, you are responsible for filling out the medical information on those patients.
4. If clients are referred to individual physicians who receive CARE Act funds, should these clients be reported in Section 5?	Yes. If the physicians receive CARE Act funds, then the clients they serve must be reported in Section 5.
5. Item 44: Can providers report percentages for Item 44?	No. Providers must report actual numbers for this item.

6. Item 45: Should clients who are new to our program be reported or only those clients who are new to our program and simultaneously new to HIV/AIDS medical care?	Report any and all clients new to HIV/AIDS medical care, regardless of whether they've received non-medical services from your agency in previous years. The number of clients new to medical care may be more or less than the number of new HIV-positive/indeterminate clients reported in Item 32 (or Item 24).
7. Items 46-53: If providers know the exposure data for their clients but do not have access to the rest of the information in Section 5, should they fill in the exposure data?	Medical service providers should report all medical information available to them. However, they should make every effort to obtain all the medical information included in Section 5.
8. Items 47-48: What is the definition of "treatment" in Item 48? Does it mean prescribed, in progress, or completed?	In Item 48, "treatment" refers to treatment that has been initiated, which can include a physician writing a prescription for medication. Note that the physician may not know if the patient filled the prescription or took the medication.
9. Item 47b: Are clients only counted if the TB skin test is planted and read?	Item 47b refers to TB tests planted.
10. Items 46-49 and 51-53: Is client self-report acceptable for these items?	No.
11. Item 48: If a client is tested at an unassociated medical facility and sends the results to our clinic, should they be included in Item 48?	Include only those clients who were tested by your HIV medical program.
12. Item 48: What if a client started treatment but didn't finish?	If a client was prescribed the treatment, they should be counted in the appropriate Treatment category.
13. Item 49: Should clients who entered our care for the first time (new to our program) with an existing AIDS diagnosis be counted?	Report all clients receiving an AIDS diagnosis (regardless of the source of diagnosis) for the first time during the reporting period. New clients entering your program already having been diagnosed should not be included.
14. Item 51: What are the criteria for including a client in Item 51 (antiretroviral therapies) at the end of the reporting period?	Any client who is on any type of antiretroviral therapy at the end of the reporting should be included in Item 51.
15. Item 51: If a client receives both dual and triple combination therapy (HAART) in one reporting year, how should they be reported on the CADR?	Report the client under the therapy they were receiving at the end of the reporting year.
16. Item 53a-e: How is a woman who is pregnant for a few weeks in one reporting period and then delivers in the next reporting period reported in Item 53a-e?	In this situation the woman would be reported in Item 53a-e for both reporting years. The child she delivers would only be reported under Items 53d and e during the second reporting year (since that was when the child was delivered).
17. Item 53c: Is this item meant to track women who are prescribed antiretroviral medications or women who actually take their antiretroviral medications?	All women who are prescribed antiretroviral medications should be reported in this item regardless of whether or not they actually take the medications.

SECTION 6: DEMOGRAPHIC TABLES/TITLE-SPECIFIC DATA FOR TITLES III AND IV	
Questions	**Answers**
1. When a multiply funded provider completes the Title IV information in Section 6.2, should the provider only report those served under Title IV programs?	The information reported in Section 6.2 should only include those served under Title IV programs.

2. Should the number of clients reported in Section 6.1 be the same as the number of unduplicated clients in Section 2?	These numbers would be equal only if the agency provided services solely to Title III funded clients. If the agency is multiply funded and serviced clients funded under a different Title, the number of clients reported in Section 6.1 would not be equal to the unduplicated client count in Section 2.
3. A Title IV grantee is also a Title II provider. How does this grantee report a 60-year-old male receiving case management services under Title II?	Report this client in other relevant sections of the CADR (i.e., Section 2 and 3); however, do not report him in Section 6.2.
4. Items 60 and 61: Under which response category should a provider report children who were exposed to HIV through sexual abuse?	Report these children under the "Other" exposure category in the tables in Items 60 and 61.
5. Item 64: If a Title III agency refers clients to a clinic within the umbrella organization, but that clinic is not funded by the CARE Act, is the referral considered outside the EIS?	No. A referral is considered outside the EIS if the clinic (1) is not part of the grantee organization; (2) does not have a contractual relationship with the grantee; and (3) does not receive reimbursement from the Title III grantee or its parent organization.
6. Item 64: If a Title III agency refers clients to a clinic considered outside the EIS, how are the services reported?	Indicate that the service was provided through referral in Item 64, and list the services in Item 33 (Section 3) as referrals.

SECTION 7 HIP INFORMATION	
Questions	**Answers**
1. In Section 7, does "new client" refer to clients who are new to the program or new to the agency?	"New clients" refers to clients who are new to the program, not clients that are new to the agency. Any client who receives his/her first service through HIP during the reporting year should be reported as a new client in Section 7. Clients that were seen in previous years at the agency but became a part of HIP for the first time during the reporting year should be reported as new clients in Section 7.
2. Is funding reported in Section 7 meant to be total Title funding or only HIP funding?	Only funding used for HIPs should be reported.